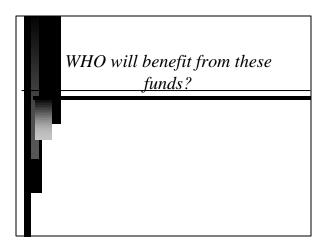
Partnerships for Youth Transition Grant November 13, 2002 Funding received from the Department of Health & Human Services, Public Health Service - Substance Abuse & Mental Health Services Administration.

Partnerships for Youth Transition ■ Awarded to Clark County Department of Community Services & Corrections. ■ Received Notice of Grant Award on 10/11/02. ■ Project period: 09/30/02 - 09/29/06. ■ Four year grant for \$500,000 per year.



Target Population: Clark County residents 14-21 years of age:

■ Who are living in or are at imminent risk of out-of home placement.

■ Who have at least one DSM-IV diagnosis that prevents them from functioning in family, school, and/or community. (This condition must be of 12 months duration, or, on the basis of diagnosis, be expected to last for at least 12 months.)

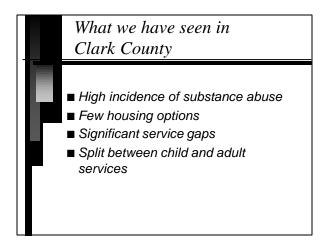
■ Who consent to treatment and (if under 18) whose parents/guardians consent to treatment.

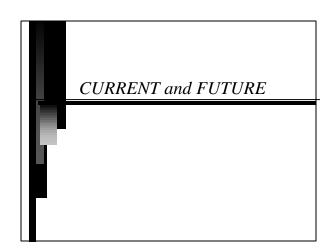
WHY is this needed in Clark

County?

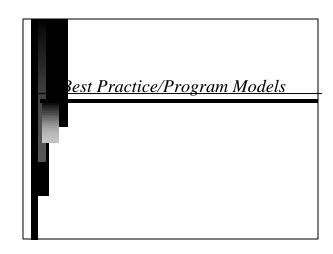
Difficulties and Barriers for Transition
Aged Youth with Emotional & Behavioral
difficulties include:

High School Completion
Post-secondary or Vocational
Education
Employment
Independent Living
Social Adjustment
Cultural Competence





Already in Place in Clark County: Individualized and Tailored Care philosophy. Capacity in every mandated service delivery area. Clark County's Children's Community of Care Advisory Council. Well established evaluation & quality assurance processes. Powerful & flexible management information system.

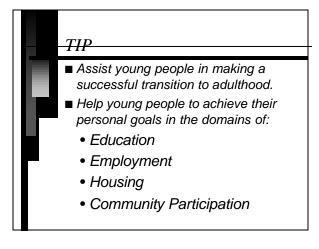


Transition to Independence

Process (TIP) System

■ Developed by Hewitt B. Clark, Ph.D. at Louis de la Parte Florida Mental Health Institute at the University of South Florida. (Clark and Davis, 2000)

■ Consistent with the model of ITC that underlies the County's fundamental approach to service delivery.



TIP's Six Guidelines

- 1. Person-Centered Planning.
- 2. Tailored Services & Support.
- 3. Continuity of Services & Support.
- 4. Unconditional commitment to the consumer ("No reject/no eject").
- 5. Achieving Greater Independence.
- 6. Outcome Orientation on both the individual & systemic levels.

Assertive Community Treatment (ACT)

- Dan Bridgeo in Columbus, Ohio.
- Used for adults with serious mental illness in Clark County.
- Supplement to the TIP approach for youth with the most intense needs.
- Transition ACT Team (TACT) will be developed as a standing team.

Blending the Models

The blending of both TIP and ACT should increase the acceptability, and potentially the effectiveness, of TIP in addressing the needs of youth with emotional and behavioral disorders.

Program Components

- Community & provider education
- Targeted education and support for families
- A community based strategic planning process
- An infrastructure that can identify & address policy and funding barriers and sustainability issues
- Enhanced employment services to the target population

Coordinated Efforts to address system gaps

- Enhance existing ITC teams with Transition Specialists
- Increase integration and coordination of existing services
- Expand the role of young adults as service providers and advocates
- Expand the role of youth in governance, service provision, and evaluation

ordinated Efforts (continued)

- Provide training to understand the developmental issues of transition age youth
- Develop specific outcome objectives on the policy level
- Develop an effective and timely information infrastructure Institute an ongoing independent evaluation

Awarded funds

- Transition Specialists.
- One new ACT team.
- Youth Job Coach & Job Developer.
- Housing support.
- Educational & peer support.
- County-wide goals & strategic plan.
- Training for line staff.

Evaluation & Performance Plan

- Integrated Management Information (IMIS) System
- Process Evaluation
 - Regional Research Institute for Human Services at Portland State University (RRI)

Governance & Oversight

Community of Care Advisory Council

Subcommittees:

- Family Action Committee
- Resource Management Committee
- Partnerships for Youth Transition

Planning Team

Membership includes:

- Youth
- Parents
- Representatives of key participating agencies

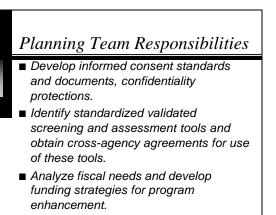
(Youth & family will compose at least 50% of team)

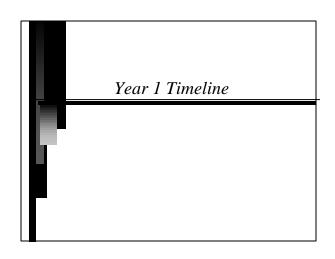
Planning Team Responsibilities

- Facilitate & oversee youth development & parent outreach activities.
- Identify training needs & trainers.
- Coordinate activities with evaluation & planning staff.
- Analyze the continuum of care, identify gaps, and develop strategies for filling those gaps.

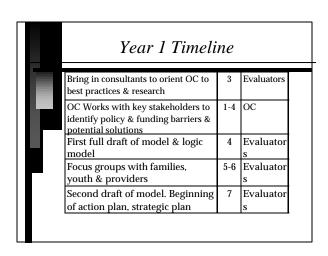
Planning Team Responsibilities

- Develop outcome benchmark recommendations for the Advisory Council.
- Design participant screening, assessment, care coordination mechanisms.
- Negotiate interagency referral, treatment, and sanction protocols.





Year 1 Time	line	
Hire Project Director	1-2	Deputy Dir.
Convene Oversight Committee (OC)	1	Deputy Dir.
Establish contracts with PSU, Clark, Vander Stoep, Franz	1	Deputy Dir.
Issue RFQ for data contractor; select contractor		Information Mgr.
Hold monthly meetings of OC	1-12	Project
Pull together data from SOC of care evaluation & other County Sources	2-3	Evaluators



Year 1 Time	line	?
Community & Provider review & input	7	Coordinated by Project Dir.
Begin hiring of transition specialist	7	Project Dir.
Training of transition specialist	10	
Entry point agencies and OC work on details of joint ICT teams & bringing up TACT		Coordinated by Project Dir.
Transition specialist begin pilot process with ITC teams	10+	Coordinated by Project Dir.

